State of Illinois
Department of Healthcare and Family Services
Department of Human Services
Illinois Medicaid Redetermination

00001
HH_NAME (ARR_ENGLISH)
ADDRESS LINE1
ADDRESS LINE2
CITY ST

00001
IMR7AZE
00-IMR2BR1E-2
ARR - EN

9010101

February 12, 2014 Case ID: 011011010011Y

Dear HH_NAME (ARR_ENGLISH),

You asked us to share information about your case.

We need you to give us permission to share your information.

Here's how to renew:

1. Please fill out the form that came with this letter, and then sign it.
2. Make a copy of the form to keep for your records.
3. Send your form to us one these ways:
   - → **Fax** your form and proofs to 1-866-661-7025
   - → **Mail** your form and proofs in the envelope that we sent you
   - → **E-mail** your form and proofs to www.medredes.hfs.illinois.gov

What if you change your mind?

You may ask us to stop sharing at any time. If you want us to stop, you can use the same form. Fill out Part 2 "Please STOP sharing my information" at the bottom of the form. Then sign your name and write the date. Make a new copy of the form to keep and send the form to us.

What if you have questions?

Please visit **www.hfs.illinois.gov/review** or call us at **1-855-458-4945** (TTY: 1-855-694-5458).

Thank you,

Illinois Medicaid Redetermination

Authorization to Share Information

Part 1: Please share my information

Fill out this part if you would like us to share information about your medical benefits with a person or organization. We will share information only with the people you write here.

My name	Social Security number (*you can choose not to write this*)
Please share my information with	

When I sign below, I know that:

- This authorization will last as long as I keep getting health benefits or until I tell you to stop sharing my information.
- I can change my mind about sharing information by signing part 2 of this form and sending it back to you by mail or fax.
- My choice to share information about my case, or to stop sharing it, will not change what benefits I can get.
- I can keep a copy of this form or call 1-855-458-4945 to get a copy.

Signature	Date
Address	Date of Birth

Part 2: Please STOP sharing my information

Sign here if you change your mind and would like us to stop sharing your information. After you sign, mail or fax this form to us. Keep a copy.

I do not want you to share my information with the person or organization on this form.

Signature	Date

Mail: Illinois Medicaid Redetermination
PO Box 1242
Chicago, Illinois 60690-1242

Fax: 1-866-661-7025

Questions? Call **1-855-458-4945** (TTY: 1-855-694-5458). The call is free!
Monday to Friday from 7 a.m. to 7:30 p.m. and Saturday from 8 a.m. to 1 p.m.
E-mail us at **www.medredes.hfs.illinois.gov** or send a fax to 1-866-661-7025.
Tenemos información en español. ¡Servicio de intérpretes gratis!
Llame al 1-855-458-4945.